6.d. Other practitioners' services. (continued)

B. **Public health nursing services.**

If the actual use of personal care assistant service varies significantly from the use projected in the service plan, the month-to-month plan must be promptly updated by the recipient or responsible party and the public health nurse.

Public health nurses who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

26. Personal care services.

Personal care services are provided by personal care provider organizations or by use of the PCA Choice option.

A. Personal care provider organizations

Personal care services provider qualifications:

- Personal care assistants must be employees of or under contract with a personal care provider organization within the service area. If there are not two personal care provider organizations within the service area, the Department may waive this requirement. If there is no personal care provider organization within the service area, the personal care assistant must be enrolled as a personal care provider.

- If a recipient's diagnosis or condition changes, requiring a level of care beyond that which can be provided by a personal care provider, non-Medicare certified personal care providers must refer and document the referral of dual eligibles to Medicare providers (when Medicare is the appropriate payer).

- Effective July 1, 1996, personal care assistant means a person who:

  a) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

  b) is able to effectively communicate with the recipient and the personal care provider organization;

  c) is able to and provides covered personal care services according to the recipient's plan of care, responds appropriately to the recipient's needs, and reports changes in the recipient's conditions to the supervising qualified professional. For the purposes of this item, "qualified professional" means a

26. Personal care services. (continued)

registered nurse or a mental health professional defined in item 6.d.A. of this attachment;

d) is not a consumer of personal care services; and

e) is subject to criminal background checks and procedures specified in the state human services licensing act.

- Effective July 1, 1996, personal care provider organization means an entity enrolled to provide personal care services under medical assistance that complies with the following:

a) owners who have a five percent interest or more, and managerial officials are subject to a background study. This applies to currently enrolled personal care provider organizations and those entities seeking to enroll as a personal care provider organization. Effective November 10, 1997, an organization is barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in the state human services licensing act, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in the state human services licensing act;

b) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provide proof thereof. The insurer must notify the Department of the cancellation or lapse of policy; and

c) the organization must maintain documentation of personal care services as specified in rule, as well as evidence of compliance with personal care assistant training requirements.

26. Personal care services. (continued)

B. PCA Choice option

Under this option, the recipient and qualified professional do not require professional delegation.

- The recipient or responsible party:

a) uses a PCA Choice provider, not a personal care provider organization. A PCA Choice provider assists the recipient to account for covered personal care assistant services. A PCA Choice provider is considered a joint employer of the qualified professional described in item A and the personal care assistant, and may not be related to the recipient, qualified professional, or personal care assistant. A PCA Choice provider or owner of the entity providing PCA Choice services must pass a criminal background check according to the state human services licensing act;

b) uses a qualified professional for help in developing and revising a plan to meet the recipient's assessed needs and for help in supervising the personal care assistant services, as recommended by a public health nurse;

c) supervises the personal care assistant if there is no qualified professional;

d) with the PCA Choice provider, hires and terminates the qualified professional;

e) with the PCA Choice provider, hires and terminates the personal care assistant;

f) orients and trains the personal care assistant in areas that do not require professional delegation as determined by the county public health nurse;

26. Personal care services. (continued)

g) supervises and evaluates the personal care assistant in areas that do not require professional delegation as determined in the assessment;

h) cooperates with the qualified professional and implements recommendations pertaining to the health and safety of the recipient;

i) with the PCA Choice provider, hires a qualified professional to train and supervise the performance of delegated tasks done by the personal case assistant;

j) monitors services and verifies in writing the hours worked by the personal care assistant and the qualified professional;

k) develops and revises a care plan with assistance from the qualified professional;

l) verifies and documents the credentials of the qualified professional; and

m) together with the PCA Choice provider, qualified professional, and personal care assistant, enters into a written agreement before services begin. The agreement must include:

1) the duties of the recipient, PCA Choice provider, qualified professional, and personal care assistant;

2) the salary and benefits for the qualified professional and personal care assistant;

3) the administrative fee of the PCA Choice provider and services paid for with that fee, including background checks;

4) procedures to respond to billing or payment complaints; and

26. Personal care services. (continued)

5) procedures for hiring and terminating the qualified professional and personal care assistant.

The PCA Choice provider:

a) enrolls in medical assistance;

b) requests and secures background checks on qualified professionals and personal care assistants according to the state human services licensing act;

c) bills for personal care assistant and qualified professional services;

d) pays the qualified professional and personal care assistant based on actual hours of services provided;

e) withholds and pays all applicable federal and state taxes;

f) makes the arrangements and pays unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

g) verifies and documents hours worked by the qualified professional and personal care assistant; and

h) ensures arm's length transactions with the recipient and personal care assistant.

At a minimum, qualified professionals visit the recipient in the recipient's home at least once every year. Qualified professionals:

a) report to the county public health nurse concerns relating to the health and safety of the recipient; and

26. Personal care services. (continued)

b) report to the appropriate authorities any suspected abuse, neglect, or financial exploitation of the recipient.

As part of the assessment and reassessment process in item 6.d.B. of this attachment, the following must be met to use, or continue to use, a PCA Choice provider:

a) the recipient must be able to direct the recipient's own care, or the responsible party for the recipient must be readily available to direct the care of the personal care assistant;

b) the recipient or responsible party must be knowledgeable of the health care needs of the recipient and be able to effectively communicate those needs;

c) the recipient cannot receive shared personal care services (shared services); and

d) a service update cannot be used in lieu of an annual reassessment.

Authorization to use the PCA Choice option will be denied, revoked, or suspended if:

a) the public health nurse or qualified professional determines that use of this option jeopardizes the recipient's health and safety;

b) the parties do not comply with the written agreement; or

c) the use of the option results in abusive or fraudulent billing.

The recipient or responsible party may appeal this decision. A denial, revocation or suspension will not affect the recipient's authorized level of personal care assistant services.

26. Personal care services. (continued)

Amount, duration and scope of personal care services:

- Department prior authorization is required for all personal care services and supervision. Prior authorization is based on the physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; primary payer coverage determination information as required; the service plan; and cost effectiveness when compared to other care options. The Department may authorize up to the following amounts of personal care service:

  a) up to 2 times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level;

  b) up to 3 times the average number of direct care hours provided in nursing facilities for recipients with complex medical needs, or who are dependent in at least seven activities of daily living and need either physical assistance with eating or have a neurological diagnosis;

  c) up to 60 percent of the average payment rate for care provided in a regional treatment center for recipients who exhibit, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors:

     1) self-injury;
     2) physical injury to others; or
     3) destruction of property;

  d) up to the amount medical assistance would pay for care provided in a regional treatment center for recipients referred by a regional treatment center preadmission evaluation team; or

  e) up to the amount medical assistance would pay for facility care for recipients referred by a preadmission screening team; and

26. Personal care services. (continued)

f) a reasonable amount of time for the provision of supervision of personal care services.

- Department prior authorization is also required if more than two reassessments to determine a recipient's need for personal care services are needed during a calendar year.

- Personal care services must be prescribed by a physician. The service plan must be reviewed and revised as medically necessary at least once every 365 days.

- For personal care services

  a) effective July 1, 1996, the amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers;

  b) effective July 1, 1996, if the recipient's medical need changes, the recipient's provider may request a change in service authorization; and

  c) as of July 1, 1998, in order to continue to receive personal care services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the Department. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this attachment.

- All personal care services must be supervised as described in this item. A reasonable amount of time for the provision of supervision shall be authorized.

26. Personal care services. (continued)

- Personal care services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), institution for mental disease, or licensed health care facility.

- Recipients may use approved units of service outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Effective July 1, 1996, total hours for personal care services, whether performed inside or outside a recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting.

- Recipients may receive shared personal care services (shared services), defined as providing personal care services by a personal care assistant to two or three recipients at the same time and in the same setting. For purposes of this item, "setting" means the home or foster care home of one of the recipients, ~~or~~ a child care program in which all recipients served by one personal care assistant are participating, which has state licensure or is operated by a local school district or private school, or outside the home or foster care home when normal life activities take recipients outside the home or foster care home. The provider must offer the recipient or responsible party the option of shared services; if accepted, the recipient or responsible party may withdraw participation in shared services at any time.

  In addition to the documentation requirements for personal care provider service records in state rule, a personal care provider must meet documentation requirements for shared services and must document the following in the health service record for each recipient sharing services:

  a) permission by the recipient or responsible party for the maximum number of shared services hours per week chosen by the recipient;

26. Personal care services. (continued)

b) permission by the recipient or responsible party for personal care assistant services provided outside the recipient's home;

c) permission by the recipient or responsible party for others to receive shared services in the recipient's home;

d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;

e) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;

f) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

g) daily documentation of the shared services provided by each identified personal care assistant including:

1) the names of each recipient receiving share services together;

2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

3) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care

26. Personal care services. (continued)

issues, and other notes as required by the qualified professional.

In order to receive shared services:

a) the recipient or responsible party, in conjunction with the county public health nurse, must determine:

1) whether shared services is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared services allocated as part of the overall authorization of personal care services;

b) the recipient or responsible party, in conjunction with the supervising qualified professional, must arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the supervising qualified professional, must consider and document in the recipient's health service record:

1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are appropriately and safely met. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;

3) the setting in which the shared services will be provided;

26. Personal care services. (continued)

4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

5) a contingency plan that accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

- The following personal care services are covered under medical assistance as personal care services:

a) bowel and bladder care;

b) skin care to maintain the health of the skin;

c) repetitive range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

d) respiratory assistance;

e) transfers and ambulation;

f) bathing, grooming, and hair washing necessary for personal hygiene;

g) turning and positioning;

h) assistance with furnishing medication that is self-administered;

i) application and maintenance of prosthetics and orthotics;

j) cleaning medical equipment;

k) dressing or undressing;

l) assistance with eating, meal preparation and necessary grocery shopping;

26. Personal care services. (continued)

- The above limitations do not apply to medically necessary personal care services under EPSDT.

- The following services are **not covered** under medical assistance as personal care services:

  a) health services provided and billed by a provider who is not an enrolled personal care provider;

  b) personal care services that are provided by the recipient's spouse, legal guardian, parent of a recipient under age 18, or the recipient's responsible party;

  c) personal care services that are provided by the recipient's adult child or sibling, or the adult recipient's parent, unless these relatives meet one of the hardship criteria, below, and receive a waiver from the Department. As of July 1, 2000, any of these relatives who are also guardians or conservators of adult recipients, when the guardians or conservators are not the owner of the recipient's personal care provider organization, are included in this list.

     The hardship waiver criteria are:

     1) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

     2) the relative goes from a full-time job to a part-time job with less compensation to provide personal care for the recipient;

     3) the relative takes a leave of absence without pay to provide personal care for the recipient;

26. Personal care services. (continued)

4) the relative incurs substantial expenses by providing personal care for the recipient; or

5) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient.

d) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;

e) services provided by the residential or program license holder in a residence for more than four persons;

f) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

g) sterile procedures;

h) giving of injections of fluids into veins, muscles, or skin;

i) homemaker services that are not an integral part of a personal care service;

j) home maintenance or chore services;

l) personal care services when the number of foster care residents is greater than four;

26. Personal care services. (continued)

m) personal care services when combined with home health services, private duty nursing services, and foster care payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution. This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most cost-effective, medically appropriate services;

n) services not specified as covered under medical assistance as personal care services;

o) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;

p) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided (applies to foster care settings);

q) effective January 1, 1996, personal care services that are not in the service plan;

r) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

s) services to other members of the recipient's household;

t) any home care service included in the daily rate of the community-based residential facility where the recipient resides;

u) personal care services that are not ordered by the physician; or

26. Personal care services. (continued)

v) services not authorized by the commissioner or the commissioner's designee.

26. Personal care services. (continued)

4) turning and positioning;

5) application and maintenance of prosthetics and orthotics;

6) dressing or undressing;

7) assistance with eating, nutrition and diet activities;

8) redirection, monitoring, observation and intervention for behavior; and

9) assisting, monitoring, or prompting the recipient to complete the services in subitems 1) through 8).

- To receive personal care services, the recipient or responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- School districts must secure informed consent to bill for personal care services. For the purposes of this item, "informed consent" means a written agreement, or an agreement as documented in the record, by a recipient or responsible party in accordance with Minnesota Statutes, section 13.05, subdivision 4, paragraph (d) and Minnesota Statutes, section 256B.77, subdivision 2, paragraph (p).

6.d. Other practitioners' services. (continued)

B. **Public health nursing services** are paid the lower of:

1) submitted charge; or

2) State agency established rates based on comparable rates for services provided by a nurse practitioner in an office setting, or by a home health nurse in a home setting or by a nurse providing perinatal high risk services under item 20, Extended services to pregnant women.

Public health nurses who administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

~~Effective July 1, 1999, the~~ The rates for these three personal care services are as follows:

Service	July 1, 1999	July 1, 2000
Initial Public Health Nursing Assessment Visit for Personal Care Services (in-person)	$218.92/visit	$232.06/visit
Public Health Nursing Reassessment Visit for Personal Care Services (in-person)	$218.92/visit	$232.06/visit
Public Health Nursing Service Update	$109.46/update	$116.03/update

~~Effective July 1, 2000, the above rates for public health nurse review of need for personal care services is increased by three percent.~~

7.a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Payment is the lower of:

1) submitted charge; or

2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in the calendar year specified in state legislation governing maximum payment rates.

Effective July 1, 1994, this payment rate is increased by three percent.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999	July 1, 2000
X5284 Skilled Nurse Visit	$52.79/visit	$54.37/visit	$56.54/visit	$59.93/visit

Immunizations and other injectables are paid using the same methodology as Item 2.a., Outpatient hospital services.

Home health agencies that administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

7.b. Home health aide services provided by a home health agency.

Payment is the lower of:

1) submitted charge; or

2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in the calendar year specified in state legislation governing maximum payment rates.

Effective July 1,1994, this payment rate is increased by three percent.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999	July 1, 2000
X5285 Home Health Aide Visit	$40.50/visit	$41.72/visit	$43.39/visit	$45.99/visit

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

For services provided by a **home health agency**, payment is the lower of:

(1) submitted charge; or

(2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in calendar year 1982.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999	July 1, 2000
X5280 Physical Therapy Visit	$49.51/visit	$51.00/visit	$53.04/visit	$56.22/visit
X5281 Speech Therapy Visit	$50.27/visit	$51.78/visit	$53.85/visit	$57.08/visit
X5282 Occupational Therapy Visit	$50.53/visit	$52.05/visit	$54.13/visit	$57.38/visit
X5283 Respiratory Therapy Visit	$36.75/visit	$37.85/visit	$39.36/visit	$41.72/visit

Services provided by **rehabilitation agencies** are paid using the same methodology as item 5.a., Physicians' services, except that payments are increased by 38% for physical therapy, occupational therapy, and speech pathology services provided by an entity that:

(1) is licensed under Minnesota Rules, parts 9570.2000 to ~~9570.3600~~ 9570.3400 that operate residential programs and services for the physically handicapped;

2) is Medicare certified as a comprehensive outpatient rehabilitation facility as of January 1, 1993; and

(3) for which at least 33% of the patients receiving rehabilitation services in the most recent calendar year are recipients of medical assistance, general assistance medical care, and MinnesotaCare.

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

For services provided by a **home health agency**, payment is the lower of:

(1) submitted charge; or

(2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in calendar year 1982.

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999	July 1, 2000
X5280 Physical Therapy Visit	$49.51/visit	$51.00/visit	$53.04/visit	$56.22/visit
X5281 Speech Therapy Visit	$50.27/visit	$51.78/visit	$53.85/visit	$57.08/visit
X5282 Occupational Therapy Visit	$50.53/visit	$52.05/visit	$54.13/visit	$57.38/visit
X5283 Respiratory Therapy Visit	$36.75/visit	$37.85/visit	$39.36/visit	$41.72/visit

Services provided by **rehabilitation agencies** are paid using the same methodology as item 5.a., Physicians' services, except that payments are increased by 38% for physical therapy, occupational therapy, and speech pathology services provided by an entity that:

(1) is licensed under Minnesota Rules, parts 9570.2000 to ~~9570.3600~~ 9570.3400 that operate residential programs and services for the physically handicapped;

(2) is Medicare certified as a comprehensive outpatient rehabilitation facility as of January 1, 1993; and

(3) for which at least 33% of the patients receiving rehabilitation services in the most recent calendar year are recipients of medical assistance, general assistance medical care, and MinnesotaCare.

8. Private duty nursing services.

Payment is the lower of the submitted charge; or the following:

Procedure Code	January 1, '93	July 1, '94	July 1, '97	July 1, '98	July 1, '99	July 1, '00
X5641 Independent Private Duty R.N.	$3.71/unit	$3.82/unit	$4.01/unit	$4.13/unit	$4.30/unit	$4.56/unit
X5642 Independent Private Duty L.P.N.	$2.78/unit	$2.86/unit	$3.00/unit	$3.09/unit	$3.21/unit	$3.40/unit
X5646 Private Duty R.N.	$5.49/unit	$5.65/unit	$5.93/unit	$6.11/unit	$6.35/unit	$6.73/unit
X5647 Private Duty R.N. (for vent dependent recipient)	$6.18/unit	$6.37/unit	$6.69/unit	$6.89/unit	$7.17/unit	$7.60/unit
X5648 Private Duty L.P.N.	$4.20/unit	$4.33/unit	$4.55/unit	$4.69/unit	$4.88/unit	$5.17/unit
X5649 Private Duty L.P.N. (for vent dependent recipient)	$4.89/unit	$5.04/unit	$5.29/unit	$5.45/unit	$5.67/unit	$6.01/unit

NOTE: 1 unit = 15 minutes

Shared care: For two recipients sharing care, payment is one and one-half times the payment for serving one recipient who is not ventilator dependent. This paragraph applies only to situations in which both recipients are present and received shared care on the date for which the service is billed.

24.a. Transportation.

Payment for **life support transportation** is the lower of:

(1) submitted charge; or
(2) 50th percentile of Medicare prevailing charge for 1982, plus a 10.725% increase over the base rate.

Effective July 1, 1999 this rate is increased 5%.

If the provider transports two or more persons simultaneously in one vehicle, the payment is prorated according to the schedule for special transportation services, below. Payment for ancillary services provided to a recipient during life support transportation must be based on the type of ancillary service and is not subject to proration.

Payment for **special transportation** must be the lowest of:

(1) submitted charge; or
(2) medical assistance maximum allowable charge, which is a base rate of $15.00 ~~base rate~~ and ~~$1.20~~ , until July 1, 2001, $1.30 per mile.

If the provider transports two or more persons simultaneously in one vehicle from the same point of origin, the payment must be prorated according to the following schedule:

NUMBER OF RIDERS	PERCENT OF ALLOWED BASE RATE PER PERSON IN VEHICLE	PERCENT OF ALLOWED MILEAGE RATE
1	100	100
2	80	50
3	70	34
4	60	25
5-9	50	20
10 or more	40	10

24.a. Transportation. (continued)

Payment for **air ambulance transportation** is consistent with the level of medically necessary services provided during the recipient's transportation and is the lower of:

(1) submitted charge; or
(2) the 50th percentile of Medicare's prevailing charge for 1982, plus a 10.725% increase over the base rate.

Effective July 1, 1999 this rate is increased 5%.

Payment for air ambulance transportation of a recipient not having a life threatening condition is at the level of medically necessary services which would have been otherwise provided to the recipient at rates specified for other transportation services, above.

Payment for **special transportation for a child receiving EPSDT rehabilitative, or personal care services identified on an IFSP or IEP** and provided by a school district during the day is determined by multiplying the number of miles the child is transported to or from a provider of rehabilitative services by the per mile rate of $2.21.

26. Personal care services.

Payment is the lower of the submitted charge, or the state agency established rate:

Procedure Code	July 1, 1997	July 1, 1998	July 1, 1999	July 1, 2000
X5643 Independent Personal Care Assistant	$1.97/unit	$2.03/unit	$2.11/unit	$2.24/unit
X5644 Supervision of Independent PCA	$4.06/unit	$4.18/unit	$4.35/unit	$4.61/unit
X5645 Personal Care by an Agency 1:1	$3.09/unit	$3.18/unit	$3.31/unit	$3.51/unit
~~**X5657**~~ **X5357** Personal Care by an Agency 1:2	N/A	N/A	$2.49/unit	$2.64/unit
X5358 Personal Care by an Agency 1:3	N/A	N/A	$2.20/unit	$2.33/unit
X4037 Supervision of Personal Care by an Agency	$5.45/unit	$5.61/unit	$5.83/unit	$6.18/unit

[**NOTE**: 1 unit = 15 minutes]

Shared care: For two recipients sharing services, payment is one and one-half times the payment for serving one recipient. For three recipients sharing services, payment is two times the payment for serving one recipient. This paragraph applies only to situations in which all recipients were present and received shared services on the date for which the service is billed.

PCA Choice option: Payment is the same as that paid for personal care services.